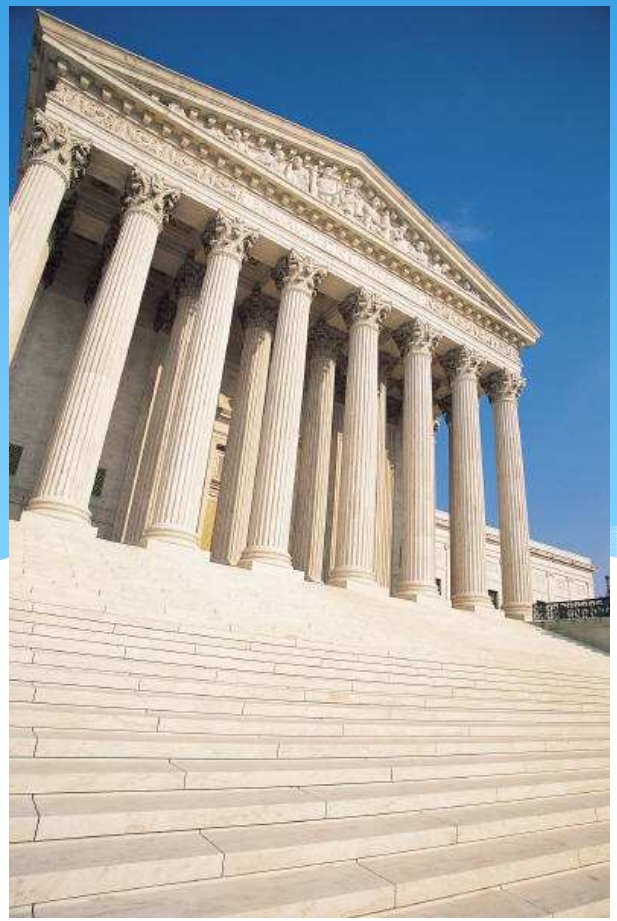
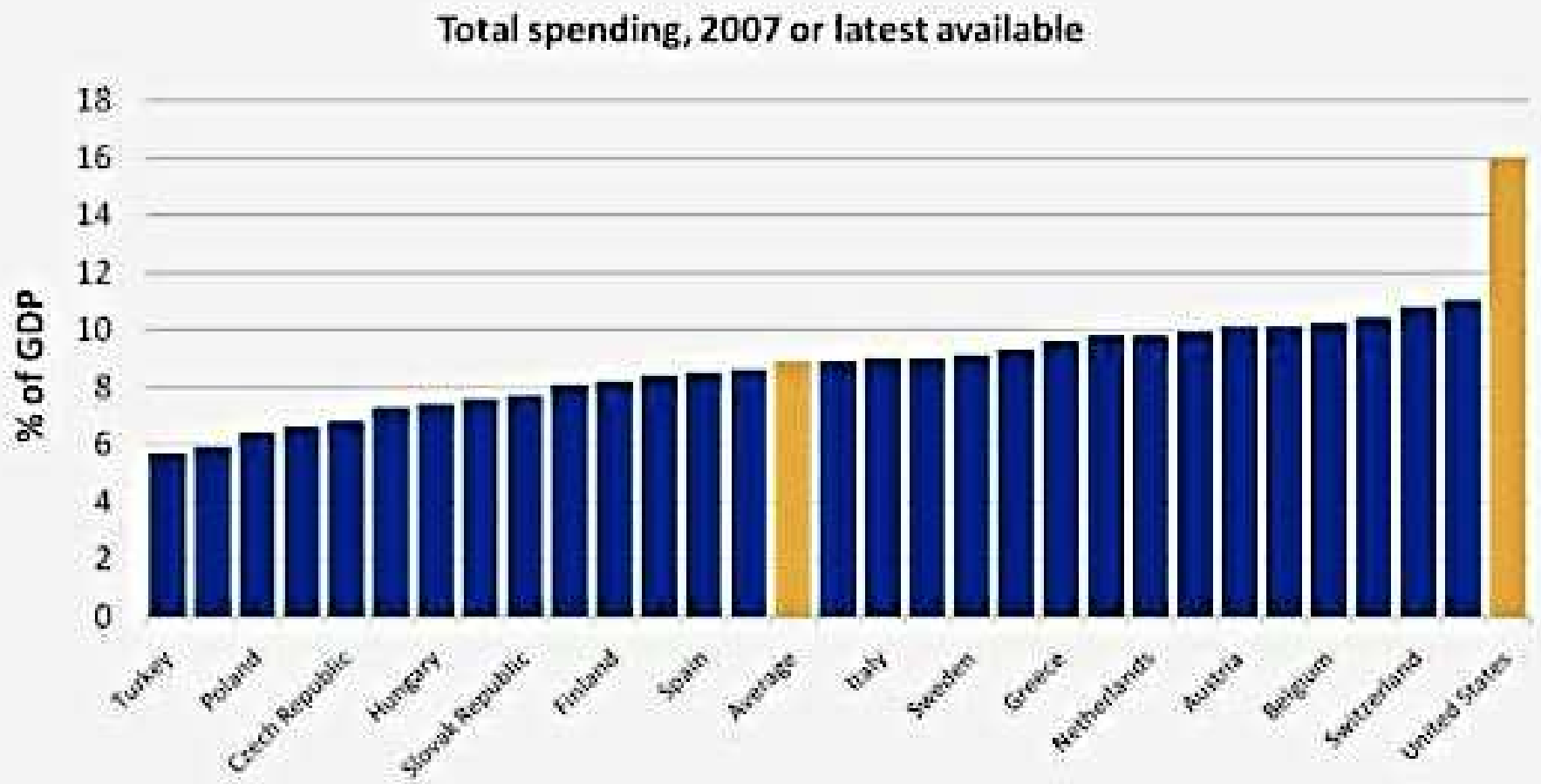
Reimbursement for Early Hearing Detection and Intervention

Robert Fifer, Ph.D.
University of Miami



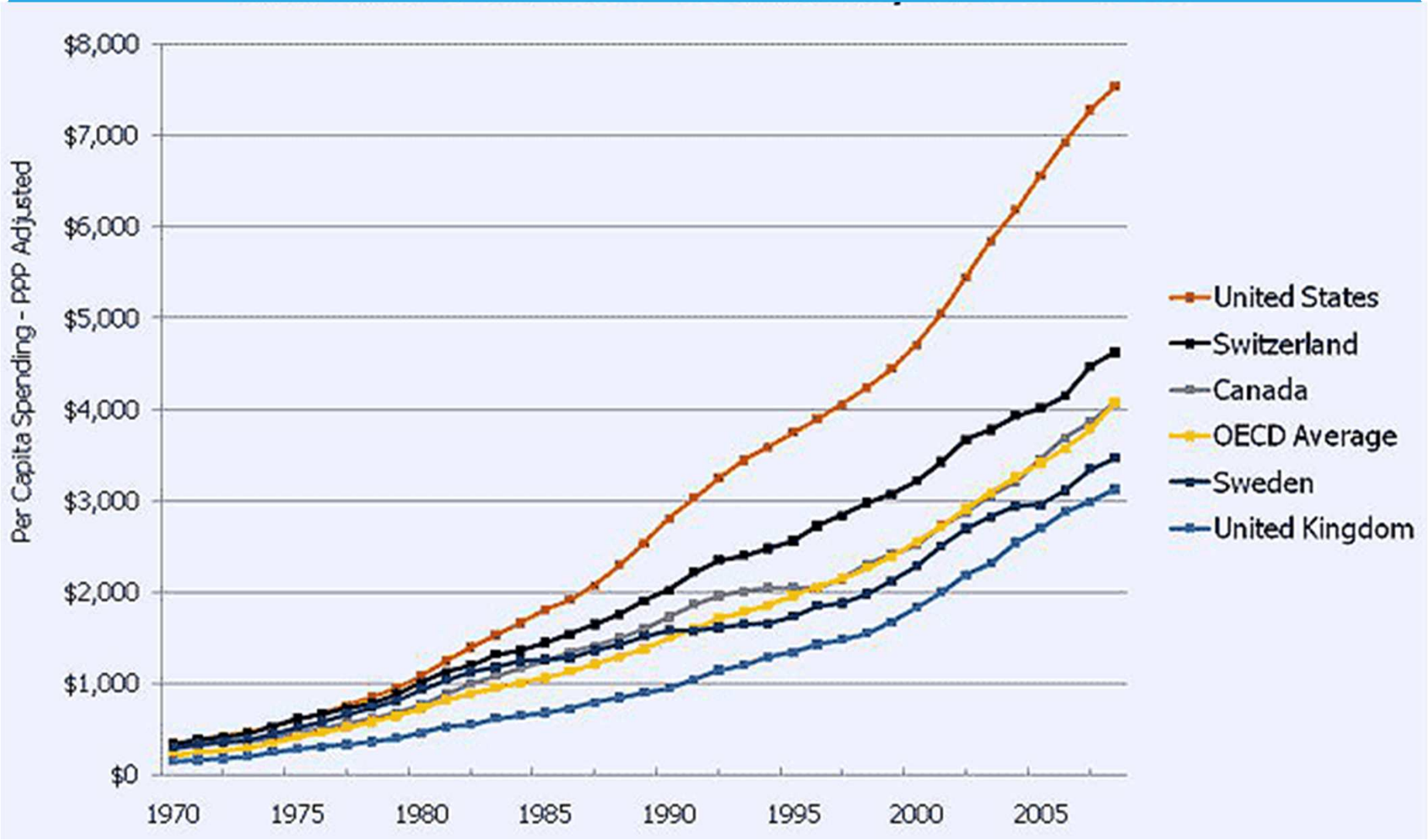
Health care economics: what got us into this mess?

Health Care Spending as a Share of GDP



OECD Health Data 2009. France: Organisation for Economic Co-operation and Development and IRDES (Institute for Research and Information in Health Economics), 2009. (No authors given.)

38 years of per capita spending by country



Satisfaction Survey by Country

Source: Gallup.com

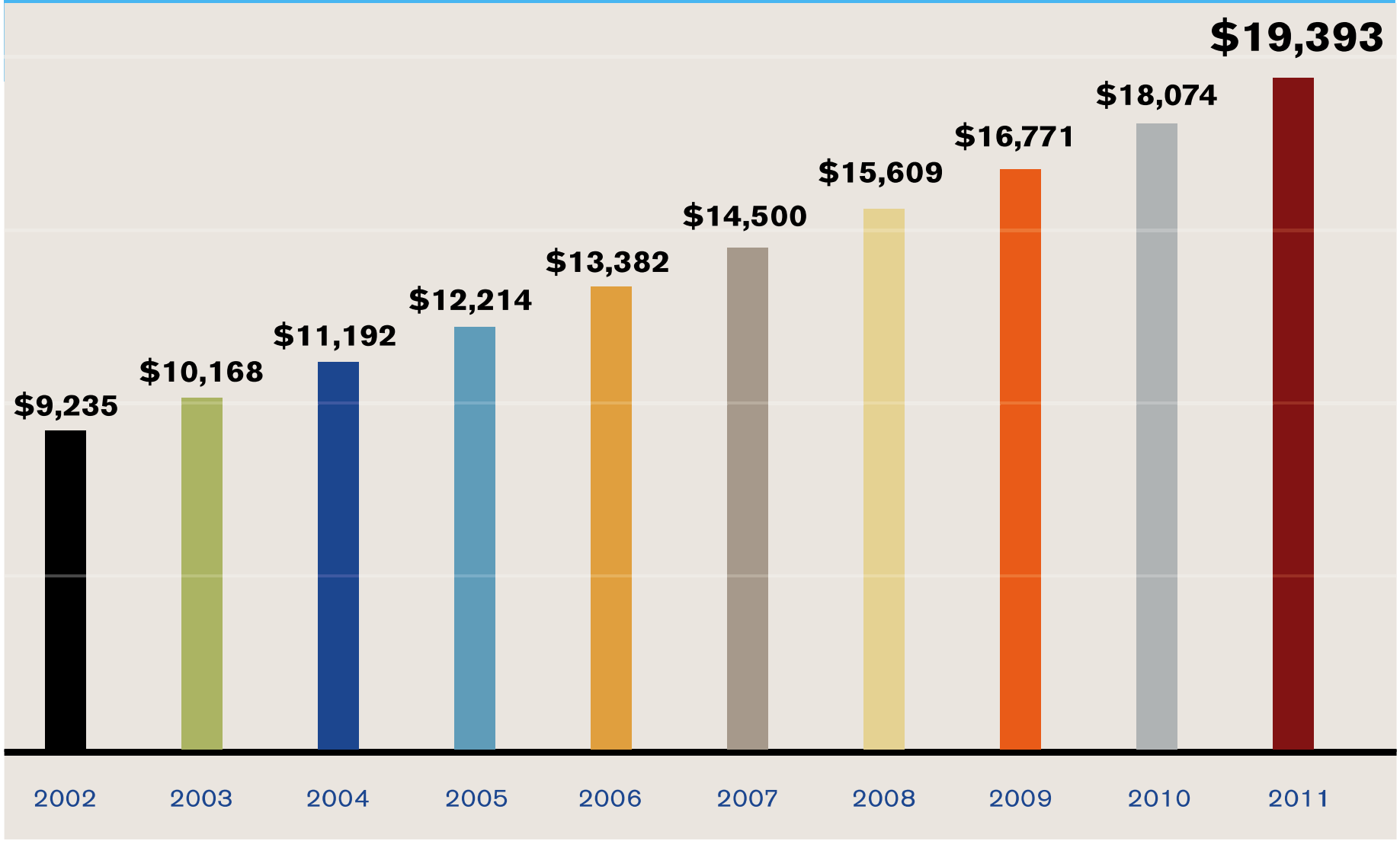
Access to Affordable Health Care

	U.S.	Great Britain	Canada
Very sat + sat	25%	43%	57%
Very unsat	44%	25%	17%

	U.S.	Great Britain	Canada
Very sat + sat	48%	44%	52%
Very unsat	26%	23%	22%

Health Care Costs for American Families

Source: Milliman Medical Index



International Health Care Rankings

Country	Health Care	Per Capita Spending
France	1	4
Italy	2	11
Spain	7	24
Austria	9	6
Japan	10	13
Norway	11	16
United Kingdom	18	26
Switzerland	20	2
Germany	25	3
Canada	30	10
United States	37	1

Factors Affecting Access

* Race/ethnicity
* Socioeconomic status
* Disparate language spoken by patient/family and physician
* Access to health insurance or Medicaid relative to enrolled providers
* Gender
  * Women have higher incidence of illness but better access to insurance
  * Men lag behind women for access to insurance

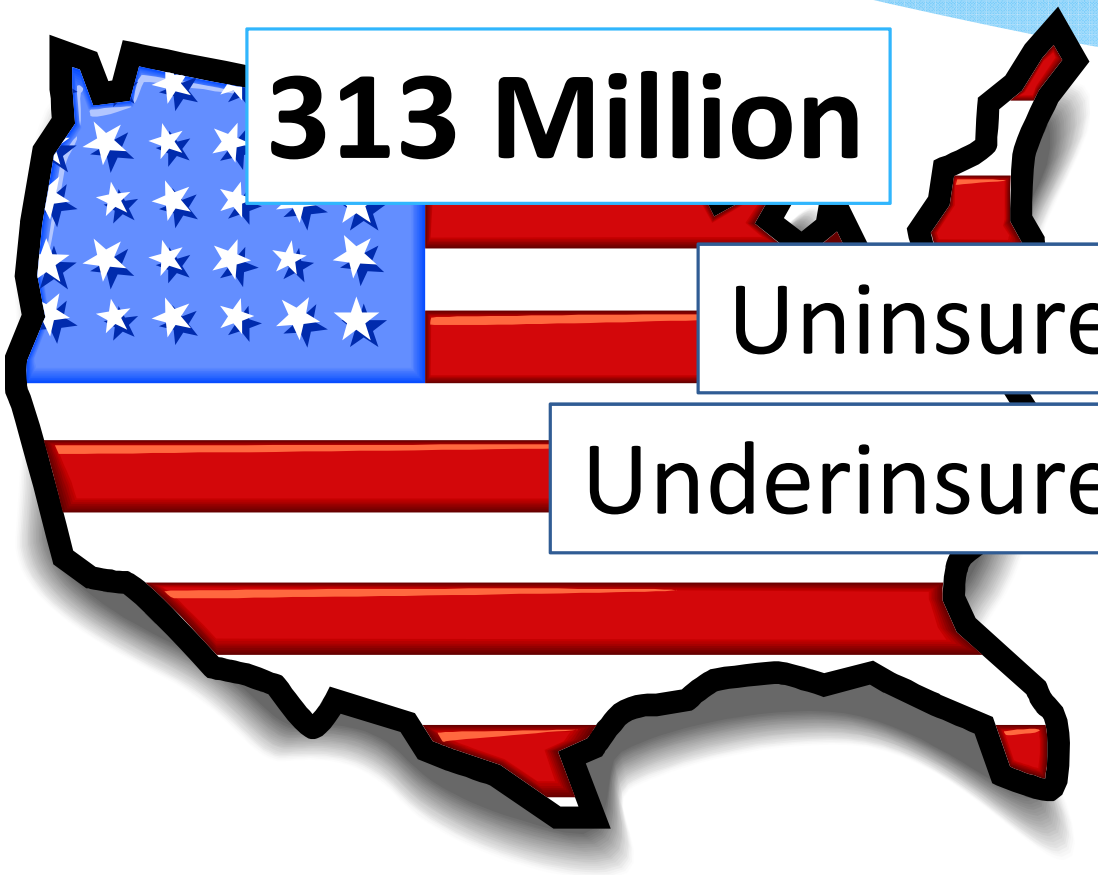
Timeline of Events

* **1970s**: Reimbursement Freeze
  * Control health care costs
  * Ended in late 1970s
* **1980s:** Costs Rise Faster Than Inflation
  * Still based on “normal and customary” fee structure
* **1990s:** RBRVS and More Restrictive Reimbursement Guidelines
  * Initial valuation based on Harvard study
  * Technology explosion

Timeline of Events

* **2000s:** Technology Advances Continue
  * Pharmaceutical direct marketing
  * Malpractice increases for high-risk specialties
  * Medicare Part D
  * End-of-life care advancements
  * Congressional "tinkering" of dollar multiplier for Medicare RVUs
  * RACs and MICs
* **2010s:** Desperation to Control Health Care Cost
  * ~800,000 households with health care insurance coverage declared medical bankruptcy
  * Revelation of uninsured, underinsured, cost-shifting

Uninsured

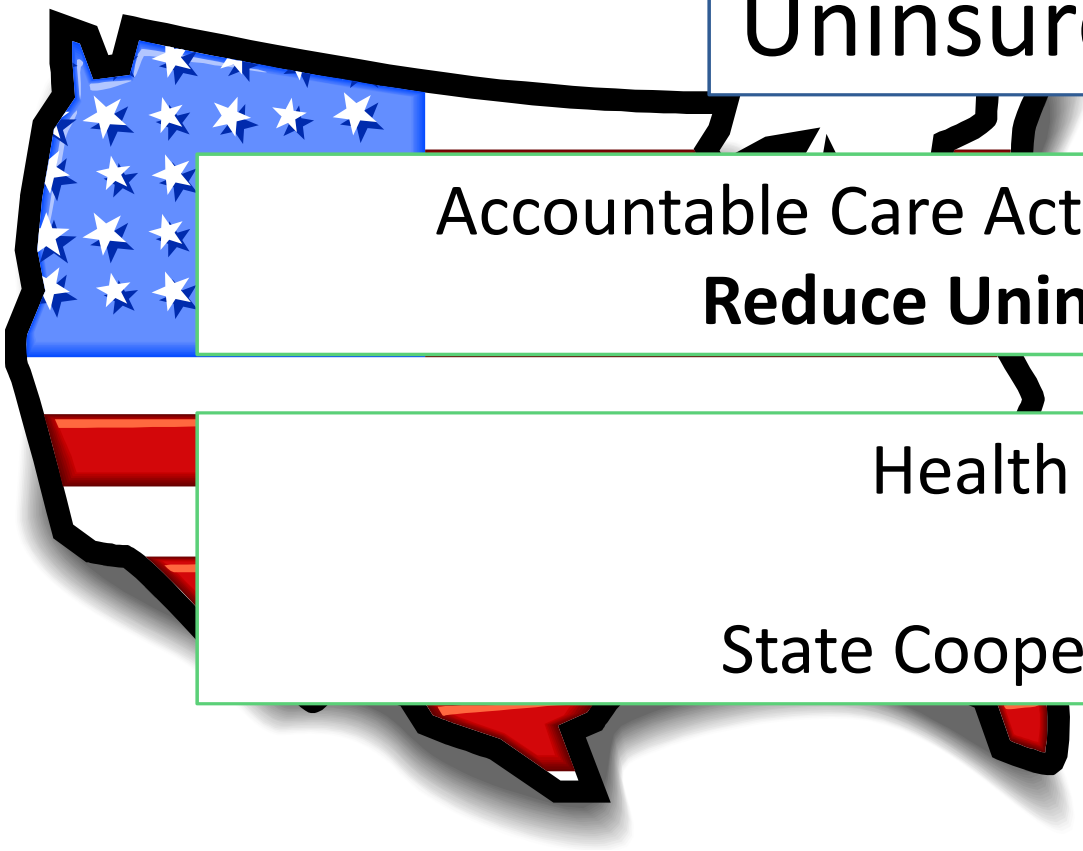


313 Million

Uninsured: ~51 Million

Underinsured: ~60 Million

Uninsured



Uninsured: ~51 Million

Accountable Care Act Health Care Reform:
Reduce Uninsured to ~18 Million

Health Insurance Exchanges
Medicaid Expansion
State Cooperation / Participation

Uninsured

* Impact on Health Care Costs:
  * Emergency room primary care
  * Delay health care services until severity increases

Health Care Economics

* Cost inflation
  * ***Risen 78% since 2000 vs. 20% for salaries***
  * Average 9% per year with range of 7%-13%
  * Defensive medicine (malpractice)
  * Unnecessary procedure/treatment (fee for service)
  * Ineffective treatment
  * Inefficient service delivery models
  * Pharmaceuticals
  * End of life care

Health Care economics: Do I turn right or left to get to the future?

Current Recommendation

* MedPAC: Move Away From Fee-for-Service
  * Encourages increased utilization
  * More services => more payment
  * Questions of true medical necessity
* IOM and CMS: Move Away From Fee-for-Service

Value-Based Purchasing

* Promote evidence-based medicine
* Require clinical and financial accountability across all settings
* Focus on episodes of care
* Better coordination of care
* Payment based on outcomes, not number of sessions (performance-based payment)
* Focus on effectiveness of treatment

Bundled Payments

* Bundled payment models de-emphasize services that increase utilization and cost
* Initiative by Center for Medicare and Medicaid Innovation called ***Bundled Payments for Care Improvement***
* Working to identify procedure groups to bundle, based on diagnosis rather than procedure(s)

Current CMS Actions to Reduce Payments

* Medicare screens for procedures reported together => new, combined procedure CPT codes (92540, 92550, 92570)
* Re-survey and re-validation of procedure value (92587)
* Bundled payments under Medicaid reform (more on this later)

Medical Home Model

* Primary care physician becomes medical manager
* All referrals will go through PCP
  * Different from “gate-keeper” concept of HMOs
  * PCP paid to coordinate and manage all care of that patient
  * With rare exception, no physician/health care provider will have “direct access” under medical home model

Diagnosis Coding

* October 1, 2014
* To International Classification of Diseases, 9th Revision, Clinical Modification ICD-10-CM

* ICD-9-CM: Approximately 18,000 codes
* ICD-10-CM: Approximately 160,000 codes
  * Provides more flexibility for adding new codes

ICD-10-CM

* **H90** Conductive and Sensorineural Hearing Loss
  * Includes:
    * Congenital deafness
  * Excludes:
    * Deaf mutism NEC (H91.3)
    * Deafness NOS (H91.9)
    * Hearing loss NOS (H91.9)
    * Noise-induced (H83.3)
    * Ototoxic (H91.0)
    * Sudden (idiopathic) (H91.2)

ICD-10-CM

* **H90.0** Conductive hearing loss, bilateral
* **H90.1** Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side
* **H90.2** Conductive hearing loss, unspecified
  * Conductive deafness NOS
* **H90.3** Sensorineural hearing loss, bilateral
* **H90.4** Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side

ICD-10-CM

* **H90.5** Sensorineural hearing loss, unspecified
  * Congenital deafness NOS
  * Hearing loss:
    * central } NOS
    * neural } NOS
    * perceptive } NOS
    * sensory } NOS
  * Sensorineural deafness NOS

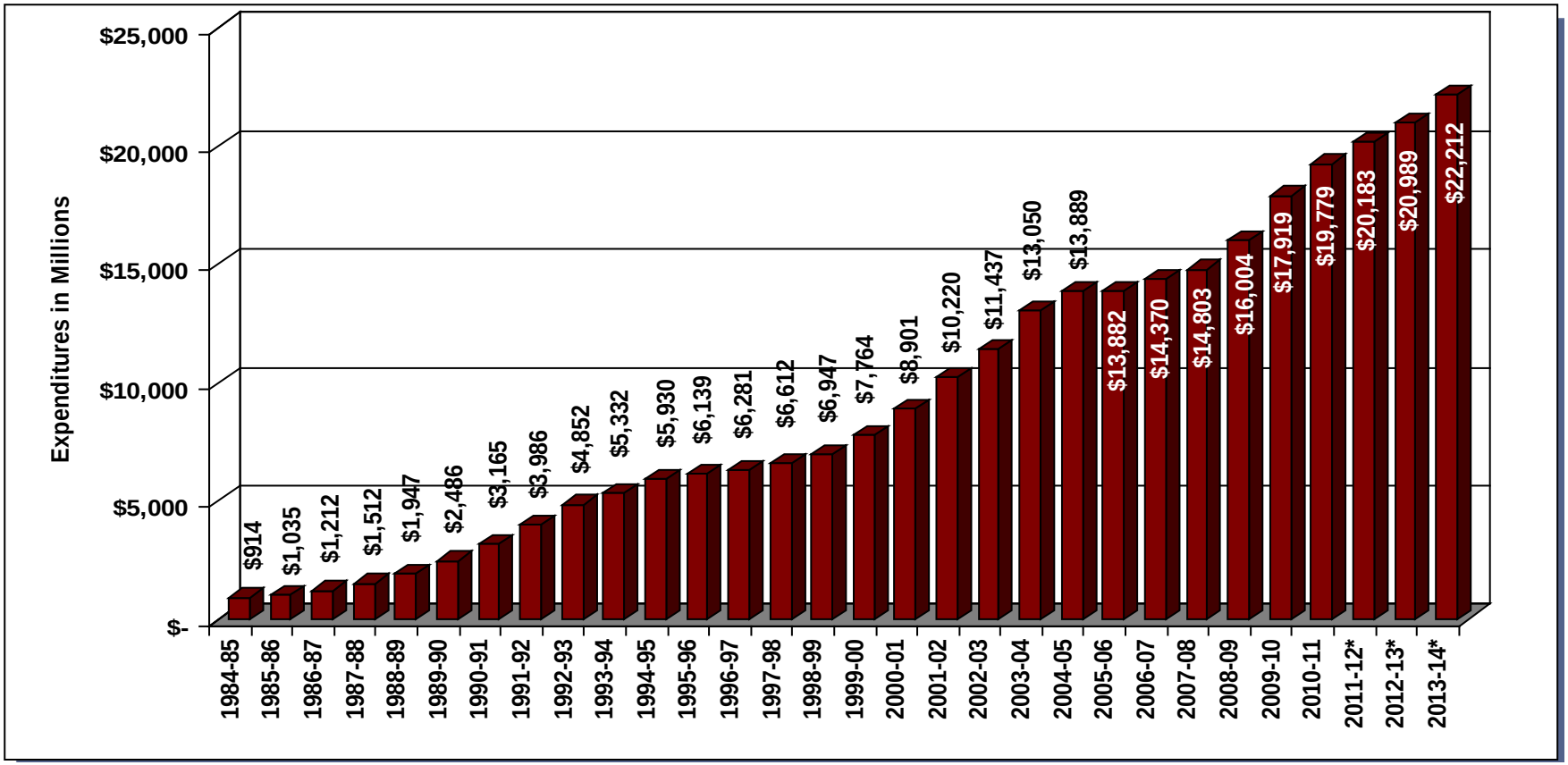
Emphasis on Outcomes

* How will the hearing loss affect the child's ability to participate in the activities of life?
* What limitations will the hearing loss create for the child's ability to
  * Engage in play activities
  * Develop academic skills
  * Participate in family activities

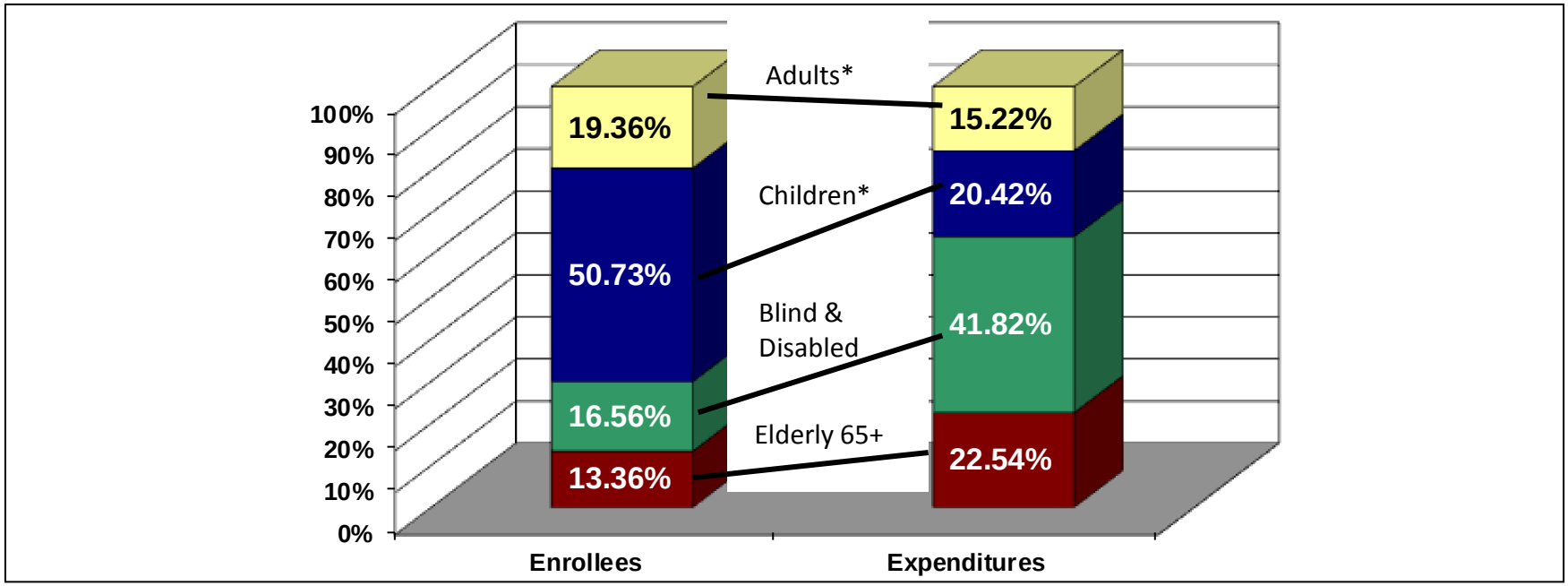
Changing Landscape

* International Classification of Functioning, Disability and Health (ICF)
* Describes body functions, body structures, activities, and participation
* Useful for understanding and measuring outcomes
* ASHA has information available online

Growth In Medicaid Service Expenditures



Florida Medicaid Budget - How it was Spent
Fiscal Year 2011-12



* Adults and children refers to non disabled adults and children.

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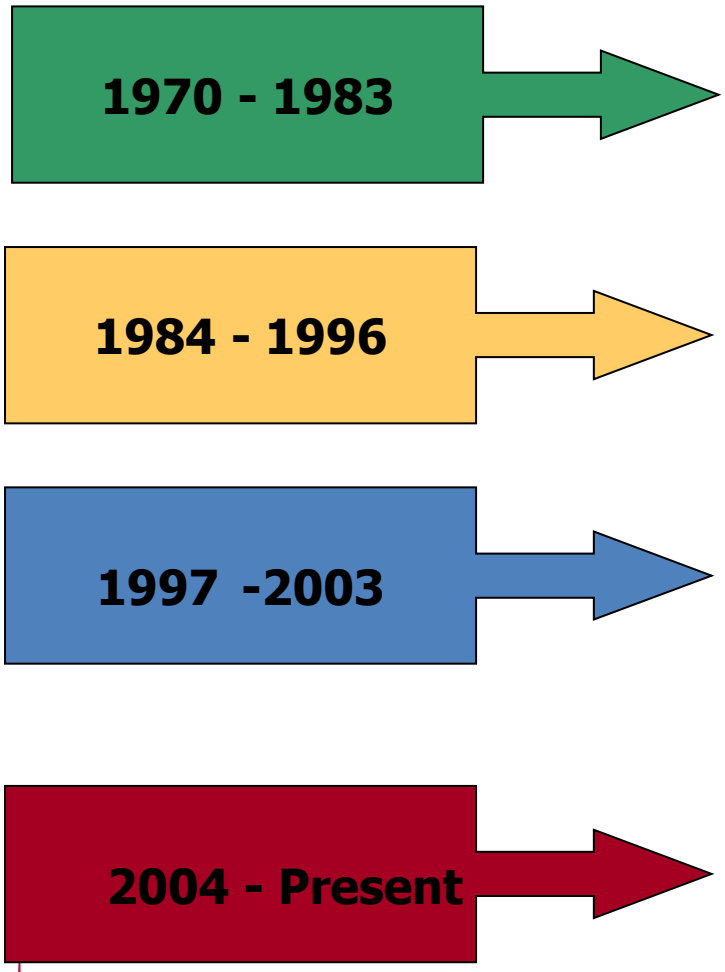
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

The Evolution of Florida Medicaid Delivery Systems



1970 - 1983

Fee-for-Service

1984 - 1996

HMOs – Since 1984
MediPass (PCCM) – Since 1991
Prepaid Mental Health Plans – Since 1996

1997 -2003

Fee-for-service Provider Service Network - Since 2000
Disease Management
Nursing Home Diversion
Prepaid Dental Plans – Since 2004

2004 - Present

Improvements in:

- **Integrated Care Management/ Care Coordination**
- **Outcomes Management/Improved Clinical Decision Making**
- **Quality Assurance**
- **Enhancements to Fraud and Abuse Controls**

New:

- **Medicaid Reform Pilot (2006)**
- **Specialty Plan (HIV/AIDS)**
- **Capitated Provider Service Networks (Since 2008)**

Medicaid Reform

* Move to privatize Medicaid in many conservative states
* Audiology:
  * Unpredictable payments
  * Restrictions on coverage
  * HMO payment panels
* Hospital changes in reimbursement:
  * From per diem to DRG
  * Newborn hearing screening exempted

Questions?

Medicaid Payments

* Continue to be “fee for service” for now
* Not all codes and procedures are recognized
* Important to read Hearing Services Handbook for authorized procedures and limitations
* Note: Florida Medicaid does NOT recognized the new screening OAE code (92558). Continue to use 92587.

Indirect Reimbursement Issues Documentation

* Necessary for
  * Reimbursement audits and appeals
  * Medical-legal requirements
  * Tracking to reduce lost to follow-up
* Elements
  * Risk factor (history)
  * Procedure (description of what was done) and Result (description of what was found)
  * Comments (assessment) (can be handled by outcome
  * Recommendations
  * Date of service
  * Signature